Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

Sarah Stillings PT
c/o Metrocrest Orthopaedics
4780 N Josey Lane
Carrollton, TX 75010

MFDR Tracking #: M4-05-2124-01

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Emp

Respondent Name and Box #:

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Insurance Co. of the State of PA
Rep. Box #: 19

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUM

Requestor's Position Summary: "The insurance denied these procedures as bundling with another procedure. Per CCI edits this procedure should be allowed separate from 97530 with modifier -59. It appears that insurance is not warranting the -59 modifier with 97530. We sent appeal but they still denied the procedure 97140 for each day of service..."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $256.00
3. CMS 1500s
4. EOBs

Sent
DEC 04 2007
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Provider asserts that modifier 59 somehow alters the effect of the mutually exclusive edits, but fails to submit any credible documentation showing that this in fact occurs under the National Correct Coding Initiative. Therefore, since 97140 and 97530 are mutually exclusive, Provider is not entitled to reimbursement."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes	Denial Codes	Part V Reference	Amount Ordered
05/06/04	97140-GP	U027	1, 2, 3, 5	$34.13
06/01/04	97140-GP	U027	1, 2, 3, 5	$34.13
06/24/04	97140-GP	U027	1, 4	$34.13
06/29/04	97140-GP	U027	1, 2, 3, 5	$34.13
Total Due:				$136.52

[redacted]

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "U027 – Reimbursement is reduced by the amount previously paid for another code mutually exclusive to this procedure."
2. Per 134.202(b), CPT code 97140 is not mutually exclusive to CPT code 97530. Therefore, reimbursement is due to Requestor.
3. CPT code 97140 has a MAR of $27.30 x 125% = of $34.13 x 4 DOS = $136.52 is recommended for reimbursement to Requestor per Rule 134.202(b).
4. Per review of Box 32 on CMS-1500, zip code 75010 is located in Dallas County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

A referral to Legal & Enforcement has been made.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$136.52** plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Gregory Formanek	11/27/07

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.